Reset

TheStandard®

Standard Insurance Company
866.756.8116 Tel 866.751.5174 Fax
PO Box 3877 Portland OR 97208

Applying For Paid Family And Medical Leave (PFML)

To Use Paid Family And Medical Leave For:
Your own serious health condition

Complete Form PFML-1
- ☐ Complete PFML-1, Part A
- ☐ Provide PFML-1 to employer
- ☐ Employer completes PFML-1, Part B and returns to you within 3 days

Complete Form PFML-6
- ☐ Complete PFML-6 and give to Health Care Provider
- ☐ Health Care Provider keeps PFML-6

Complete Form PFML-7
- ☐ Complete “Employee” information at the top of PFML-7
- ☐ Provide PFML-7 to your Health Care Provider
- ☐ Health Care Provider completes PFML-7 and returns to you

Send forms and documents
- ☐ Send completed forms and supporting documentation to The Standard
- ☐ The Standard accepts or denies claim within 5 days once a complete claim is received

Please keep a copy of all pages for your records.

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Request For Massachusetts Paid Family And Medical Leave (Form MA PFML-1) Instructions

- To request Massachusetts Paid Family And Medical Leave (MA PFML), the employee requesting MA PFML must complete Part A of the *Request For Massachusetts Paid Family And Medical Leave* (Form MA PFML-1). All items on the form are required unless noted as optional. The employee then provides the form to the employer to complete Part B.
- The employer completes Part B of the *Request For Massachusetts Paid Family And Medical Leave* (Form MA PFML-1) and returns it to the employee within three days.
- Additional forms are required depending on the type of leave being requested. The employee requesting leave is responsible for the completion of these forms.
- The employee submits the completed *Request For Massachusetts Paid Family And Medical Leave* (Form MA PFML-1) with the required additional form to The Standard. The employee should retain a copy of each submitted form for their records.

PART A - EMPLOYEE INFORMATION (to be completed by the employee)

The employee requesting MA PFML must complete all required information.

Massachusetts Paid Family And Medical Leave (MA PFML) Request (to be completed by the employee)

Question 10: Family member means the spouse, domestic partner, child, parent or parent of a spouse or domestic partner of the employee; a person who stood in *loco parentis* to the employee when the employee was a minor child; or a grandchild, grandparent or sibling of the employee.
Child means a biological, adopted or foster child, a stepchild or legal ward, a child to whom the employee stands in *loco parentis*.
Grandchild means a child of the employee's child.
Grandparent means a parent of the employee's parent.
Parent means the biological, adoptive, step-brother or step-sister of the employee.
Spouse means a husband or wife or domestic partner of an employee.

Question 11: If dates are "Continuous", the employee must provide the start and end dates of the requested MA PFML. These dates should be the actual dates that the MA PFML will begin and end. If uncertain, estimate the start and end dates and indicate "Dates are estimated". If dates are "Periodic", enter the dates MA PFML will be taken. Please be as specific as possible. If the dates are unknown or estimated, indicate "Dates are estimated".

If dates are estimated, The Standard may require you to submit a request for payment after the MA PFML day is taken. Payment for approved claims will be due as soon as possible but in no event more than 14 days from the date of the completed request.

Question 12: Date employer was notified. If the employee is submitting the MA PFML request to their employer with less than 30 days' advance notice from the start date of the MA PFML, the employee must explain why 30 days' notice could not be given. If the explanation will not fit in the space provided on the form, enter "See Attached" and add an attachment with the explanation. Be sure to include the employee's full name and their date of birth at the top of the attachment.

Employment Information (to be completed by the employee)

Question 14: Enter the date of hire to the best of the employee's recollection. If it has been more than a year since the date of hire, entering the year in which employment started is sufficient.

Question 18: List all other income you will be receiving while on MA PFML. Include the type/name of income and how much. Example PTO from employer for $500.00 a week.

If you are pre-submitting form: Indicate if the employee is pre-submitting their MA PFML request. Pre-submitting is defined as submitting the application in advance of an upcoming qualifying event, with certain required information missing due to the information being unknown at the time of the submitting. If pre-submitting is permitted by The Standard, the missing information must be supplied as soon as it is known. Benefits cannot be determined until all of the required information is provided.

The Standard will provide the employee a notice within five days which 1) states the claim is pending; 2) identifies what information is missing; 3) instructs how to submit the missing information. **Once all information is supplied, The Standard has 14 days to pay or deny the claim.**

If The Standard does not permit pre-submitting, The Standard must return the Request for Massachusetts Paid Family And Medical Leave within five days to the employee with an explanation that the claim should be re-submitted when all information is available.

Employee signs and dates, before giving this form to their employer to complete Part B.

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PART B - EMPLOYER INFORMATION (to be completed by the employer)

The employer of the employee requesting MA PFML must complete all information in Part B.

Question 2: If a Social Security Number is used for the Federal Employer Identification Number (FEIN), enter the Social Security Number.

Question 8. You can call the state or check through the employer portal for this information.

"Wage" or "wages" means: For the purpose of payment of benefits, the remuneration paid by one or more employers to an employee for employment during the employee's qualifying period.

Average Weekly Wage will be based on the weekly Wages in effect with the Employer on the day immediately preceding the date Family or Medical Leave under the Group Policy begins. For former Employees, the Average Weekly Wage will be based on Wages that were in effect on the last day the former Employee was in the employment of the Employer. For Covered Individuals who are paid hourly, the Average Weekly Wage is based on the hourly pay rate multiplied by the number of hours regularly scheduled to work for the Employer per week, but not more than 40 hours. If the Covered Individual does not have regular work hours, the Average Weekly Wage is based on the average number of hours worked per week for the Employer during the preceding 52 calendar weeks (or during the period of employment with the Employer if less than 52 weeks), but not more than 40 hours. If a Covered Individual has multiple Employers, the Average Weekly Wage will be calculated for each employer or Covered Business Entity separately.

Employer signs and dates, and then returns to the employee requesting MA PFML within three business days.

Be sure to complete the appropriate additional MA PFML form(s) based on the type of MA PFML leave being requested.

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Request For Massachusetts Paid Family And Medical Leave (Form MA PFML-1)

TO BE COMPLETED BY THE EMPLOYEE

Employee's name (first name, middle initial, last name)	Employee's date of birth (MM/DD/YYYY)

PART A - EMPLOYEE INFORMATION (to be completed by the employee)

1. Employee's legal name (first name, middle initial, last name)	2. Other last names, if any, under which employee has worked

3. Employee's mailing address Street	City	State	Zip Code	Country (if not USA)

4. Employee's Social Security Number or TIN	5. Employee's date of birth (MM/DD/YYYY)	6. Employee's primary telephone number ( )

7. Employee's preferred email address while on MA PFML (if available)	8. Employee's gender ☐ Male ☐ Female ☐ Not designated/Other

9. Reason for MA PFML request: ☐ Bond with child ☐ Care for family member ☐ Military qualifying event ☐ Own serious health condition ☐ Care of a family member who is a service member

10. The family member is employee's: ☐ Child ☐ Spouse or registered domestic partner ☐ Sibling ☐ Parents and legal guardians (or spouse's parent) ☐ Grandparent ☐ Grandchild

11. Will MA PFML be for a continuous period of time and/or periodic?

☐ Continuous _____ / _____ / _____ _____ / _____ / _____ ☐ Dates are estimated
MA PFML start date (MM/DD/YYYY) MA PFML end date (MM/DD/YYYY)

Identify dates periodic MA PFML will be taken:

☐ Periodic _____ ☐ Dates are estimated

If providing less than 30 days advanced notice to the employer, please explain:_____

_____

12. Date employer was notified. If providing less than 30 day's advance notice to the employer, please explain:

Employment Information (to be completed by the employee)

13. Business name	14. Employee's date of hire (MM/DD/YYYY)	14a. Employee's last day of work (MM/DD/YYYY)

15. Employee's work location Street address

City	State	Zip code	Country (if not U.S.A.)

16. Employer's telephone number for contact regarding this request. ( )	17. Is employee currently receiving Workers' Compensation Benefits? ☐ Yes ☐ No

18. List pay you will be receiving while on MA PFML, source of pay and amount.

19. Have you taken any leave in the last 52 weeks? ☐ Yes ☐ No	20. If yes list dates and type of leave.

Disclosure statement: Information regarding MA PFML benefits received by the employee, such as payments received and types of leave, will be provided to the employer.

Declaration and signature

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I am hereby making a request for paid family and medical leave benefits under the Massachusetts State Paid Family And Medical Leave Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Employee's signature	Date signed (MM/DD/YYYY)

☐ I am submitting this form in advance (see instructions about pre-submitting). I understand the insurance carrier will contact me to advise how to submit the required missing information.

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Request For
Massachusetts Paid Family And Medical Leave
(Form MA PFML-1)

TO BE COMPLETED BY THE EMPLOYEE

Employee's name (first name, middle initial, last name)	Employee's date of birth (MM/DD/YYYY)

PART B - EMPLOYER INFORMATION (to be completed by the employer)

1. Business's full legal name and mailing address			
Mailing address			
City	State	Zip code	Country (if not U.S.A.)
2. Employer's FEIN			
3. Employer's EIN	4. Employer's contact name for questions related to MA PFML		
5. Employer's contact telephone number ( )	6. Employer's contact email address		
7. Employee's date of hire (MM/DD/YYY)	7a. Employee's last day of work (MM/DD/YYY)		
8. Employee's Average Weekly Wage			
9. Employee's Typical Work Week Hours			
10a. Check Days Normally Worked ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday			
10b. Is employee hourly or salaried? ☐ Hourly ☐ Salaried			
11. List the last date the employee will receive pay, for example the last date through which sick leave benefits, if any, will be paid.			
12a. What type of paid benefits will the employee receive while on MA PFML? Include the last date through which any compensation will be paid.			
12b. If, while on fully-insured MA PFML, the employee will receive wages in the form of sick leave, PTO, vacation or an extended illness leave bank that is at least equal to the benefit under the Group Policy, will the employer be requesting reimbursement? ☐ Yes ☐ No			
13. Is the employee taking federal Family Medical Leave Act (FMLA)? ☐ Yes ☐ No	14. MA PFML policy number		
MA PFML insurance carrier's name and mailing address **Standard Insurance Company** **PO Box 3877** **Portland, OR 97208** **866-751-5174 Fax**			
Declaration and signature ☐ I affirm the employee meets the eligibility for Massachusetts Paid Family And Medical Leave. I am the person authorized to sign as the employer of the employee requesting MA PFML. My signature affirms that to the best of my knowledge and belief, the information I have provided is true and accurate.			
Employer's authorized signature	Date signed (MM/DD/YYYY)		
Title			

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Paid Family and Medical Leave
Release of Information for Own Serious Health Condition
(Form PFML-6)

Notice to the Employee About Use of this Authorization

As you may know, the Paid Family And Medical Leave Act (PFML) permits an employer or leave administrator to contact an employee's Health Care Provider, with the employee's permission, for the purpose of clarifying or authenticating an otherwise complete and sufficient PFML medical certification. For PFML purposes, "clarifying" means to understand the meaning of a response or to understand the handwriting and "authenticating" means to provide the Health Care Provider with a copy of the medical certification to verify the information on the form.

To help streamline PFML administration and minimize the need to contact you during leave, we have developed the attached PFML Authorization. By signing the Authorization, you provide Standard Insurance Company (The Standard) permission to contact your Health Care Provider to clarify and/or authenticate medical certifications under PFML. You are not required to complete and sign the Authorization for The Standard to process your request for PFML leave. However, completing and signing the Authorization now may shorten the time it takes to clarify or authenticate a medical certification later.

If you decide to sign the Authorization now, you may still revoke it at any time. In addition, before contacting your Health Care Provider to clarify and/or authenticate a medical certification, we will notify you in writing and explain the: (1) specific reason(s) we want to clarify and/or authenticate the certification; (2) information required to clarify and/or authenticate the certification; and (3) time period within which you and/or your Health Care Provider must provide the information needed to clarify and/or authenticate the certification.

If you would like us to authorize now any future PFML clarification or authentication, please review the Authorization carefully and complete, sign and return the Authorization to the address above.

I authorize any physician, medical practitioner or Health Care Provider (referred to as "health provider") who has completed a medical certification form for _____ (patient name) to discuss with or disclose to STANDARD INSURANCE COMPANY, my health information needed to clarify statements or information provided by health provider on a medical certification form which had been completed by health provider.

- I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct my health provider to release and disclose without restriction information reasonably necessary to clarify or authenticate information provided on a previously completed medical certification form.
- I have the right to refuse to sign this authorization and a right to revoke this authorization at any time by sending a written statement to The Standard, 1100 SW Sixth Avenue, Portland OR 97204, except to the extent the authorization has been relied upon to clarify or authenticate information. A revocation of the authorization, or the failure to sign the authorization, may impair The Standard's ability to evaluate or process the request for leave of absence.
- I understand that in the course of conducting its business The Standard may disclose information to my employer regarding my leave of absence request and status, including a completed return to work authorization form.
- I understand that the information disclosed to The Standard pursuant to this authorization may be subject to redisclosure with my authorization or as otherwise permitted or required by federal or state law. Information retained and disclosed by The Standard may not be protected under the Health Insurance Portability and Accountability Act [HIPAA].
- I understand and agree that this authorization is valid for 12 months from the date signed below.
- A photocopy or facsimile of this authorization is as valid as the original and will be provided to me upon request.

Name (please print)	
Signature of Claimant/Representative	Date

If signature is provided by legal representative (e.g., Attorney in Fact, guardian or conservator), please attach documentation of legal status.

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Paid Family And Medical Leave Certification for Own Serious Health Condition (Form PFML-7)

Employee's Name	Date of Birth

INSTRUCTIONS for HEALTH CARE PROVIDERS

This form is used to certify a serious health condition in order to qualify for Paid Family and Medical Leave (PFML). Answer each question to the best of your medical knowledge, based on your examination of the patient.

PART A: MEDICAL FACTS

1. Diagnosis: _____ Primary ICD Code: _____

   Approximate date condition commenced: _____ Probable duration of condition: _____

   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ☐ Yes ☐ No

   If so, dates of admission: _____

   _____

   Date(s) you treated the patient for condition: _____

   _____

   Will the patient need to have treatment visits at least twice per year due to the condition? ☐ Yes ☐ No

   Was the patient referred to other Health Care Provider(s) for evaluation or treatment (e.g., physical therapist)? ☐ Yes ☐ No

   If so, state the nature of such treatments and expected duration of treatment: _____

   _____

2. Is the medical condition pregnancy? ☐ Yes ☐ No If so, expected/actual delivery date: _____
3. Complications with pregnancy or delivery? ☐ Yes ☐ No If yes please explain: _____

   _____

   _____

   _____

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

   _____

   _____

   _____

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ☐ Yes ☐ No

   If so, estimate the beginning and ending dates for the period of incapacity: _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ☐ Yes ☐ No

   If so, are the treatments or the reduced number of hours of work medically necessary? ☐ Yes ☐ No

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period: _____

   _____

   _____

   _____

   Estimate the part-time or reduced work schedule the employee needs, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

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Paid Family And Medical Leave Certification for Own Serious Health Condition (Form PFML-7)

Employee's Name	Date of Birth

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ☐ Yes ☐ No

   Is it medically necessary for the employee to be absent from work during the flare-ups? ☐ Yes ☐ No

   If so, explain: _____

   _____

   _____

   _____

   Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

   Frequency: _____ times per _____ week(s) _____ month(s)

   Duration: _____ hours or ____ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Health Care Provider's Name			Date
Address	City	State	ZIP
Phone No.	Fax No.		
Specialty/Type of Practice	License No.	State	State Identification Number

Declaration and signature

My signature attests that the information provided in this form is true and correct, that I have examined the patient and answered the questions accurately and to the best of my ability, and that I am a health care provider authorized to certify their condition.

Signature of Health Care Provider	Date

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Massachusetts Paid Family and Medical Leave (PFML) Voluntary Tax Withholding Request

The tax obligations for receipt of Massachusetts Paid Family and Medical Leave benefits has not yet been established by the state. However, we want to offer you the option to address any tax obligation by providing the ability to voluntarily request tax obligations withdrawn from your MA PFML benefit. You can have both Federal and Massachusetts State tax withheld from your Paid Family and Medical Leave Benefits. Taxes will be withheld after deductions (for example, child support) are taken.

- Withholding Federal and/or Massachusetts State Tax is voluntary. 10% of your benefits would be withheld for Federal taxes and 5% would be withheld for Massachusetts State taxes.
  - If you do not have Federal and/or Massachusetts State income tax withheld, you may need to make estimated quarterly tax payments.
- The Federal and Massachusetts State Tax withheld during the year will be reported on a W-2 Form that is mailed after the end of the year.

You can stop the tax withholding at any time during your benefit claim.

- If you do not want to have income tax withheld from your weekly benefits, you do not have to return this form.
- Any monies you have withheld cannot be returned to you except by the Federal or State government as part of your income tax refund.

To **start or stop** withholding 10% Federal and/or 5% Massachusetts State Income Tax, complete the form below and return it to The Standard at PO Box 3877, Portland OR 97208.

Type or print: SSN: ___ – ___ – _____

First Name M.I. Last Name

Home Address (Number and Street or Rural Route)

City or Town State Zip Code

Telephone Number: ( ) –

Check All Boxes That Apply

- ☐ **Start** withholding 10% Federal Income Tax.
- ☐ **Stop** withholding 10% Federal Income Tax.
- ☐ **Start** withholding 5% MAS Income Tax.
- ☐ **Stop** withholding 5% MAS Income Tax.

Signature: _____ **Date:** _____

Declaration and signature: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Print